



Washington State Department of
Health
Health Professions Quality Assurance
Hearing and Speech Program
P.O. Box 47869
Olympia, WA 98504-7869

Audiologist Delegation of Supervision

NAME OF SUPERVISOR OF RECORD		LICENSE NUMBER	
NAME OF PERMIT HOLDER		PERMIT NUMBER	
SUPERVISOR'S BUSINESS ADDRESS			
CITY	STATE	ZIP	TELEPHONE ()
Delegation to Audiologist			
NAME OF DELEGATED AUDIOLOGIST			
DELEGATED AUDIOLOGIST'S SIGNATURE		DATE	
LICENSE NUMBER	FIRST ISSUE DATE		
BUSINESS ADDRESS			
CITY	STATE	ZIP	TELEPHONE ()
Duration of Training			
From	To		
Delegated Supervisor's Attestation			
I _____, do hereby certify that			
NAME OF DELEGATED SUPERVISOR			
will work under my supervision			
NAME OF PERMIT HOLDER			
performing all audiology and fitting and dispensing services during the interim permit period.			
_____ SIGNATURE OF DELEGATED SUPERVISOR		_____ DATE	
<input type="checkbox"/> Approval _____			
<input type="checkbox"/> Denial _____			